STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055932	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of three sampled residents (Residents 1) by failing to ensure the licensed nursing staff would not sign Resident 1's Medication Administration Record for antibiotic (a type of medication used to treat or prevent bacterial infections by killing bacteria or stopping their growth) therapy on three different dates (9/20/2025, 9/23/2025, and 9/25/2025) when the medication had not been delivered to the facility. This deficient practice resulted in the medical record inaccurately representing care Resident 1 did not receive and had the potential to place the resident at risk for worsening infection. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE] with medical diagnosis including multiple sclerosis (a disease in which the immune system eats away at the covering of nerves), sepsis (a life threatening complication of an infection), urinary tract infection (bladder infection), pressure ulcer stage three (full-thickness loss of skin where dead and black tissue may be visible), and neuromuscular dysfunction of bladder (bladder injury). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 1 was cognitively intact and was dependent on staff for activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Physician Orders, dated 9/20/2025, the physician's order indicated an order for Fidaxomicin (an antibiotic used to treat c-diff-inflammation of the colon) oral tablet 200 mg (milligram - a unit of measure fpr mass) give one tablet by mouth two times a day for C-diff (inflammation of the colon caused by an infection) for seven days. During a review of Resident 1's Medication Administration Record, dated September 2025, the MAR indicated Fidaxomicin was administered to Resident 1 on 9/20/2025, 9/23/2025, and 9/25/2025. During a concurrent interview and record review with the Registered Nurse (RN) 1 on 9/30/2025 at 8:50 a.m., Resident 1's Change of Condition (COC), dated 9/28/2025, was reviewed and indicated Resident 1's antibiotic medication was not delivered and administered to Resident 1. RN 1 stated a COC was initiated and the physician was notified that Resident 1's Medication Administration Record reflected the antibiotic was given on three different occasions, 9/20/2025, 9/23/2025 and 9/25/2025, however the medication had not been delivered to the facility until 9/28/2025. During an interview with the Pharmacist (PH) on 9/30/2/25 at 2:00 p.m., the PH stated the pharmacy first delivered the Resident 1's antibiotic medication on 9/28/2025. During an interview with the Director of Nurses (DON) on 9/30/2025 at 4:30 p.m., the DON stated the pharmacy delivered Resident 1's antibiotic on 9/28/2025 due to authorization problems. The DON stated the physician was called to notify him the medication was not getting authorized, and to order a different medication. The DON stated the physician did not order another medication. The DON stated the facility initiated a change of condition for the medication that was charted in error. During a review of the facility's policy and procedure (P&P) titled, Completion and Correction, 1/1/2012, the P&P indicated the facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. Entries will be recorders promptly as the events or observations occur. Entries will be complete, legible, descriptive, and accurate.